Virtual PACE Rate Methodology

Integrated Rate Methodology

One of the primary goals of the Virtual PACE initiative is to fully integrate the Medicare and Medicaid systems, including the financing of services. This goal requires an integrated rate methodology. While CMS and DHS will each make separate capitation payments to ICOs for the Medicare and Medicaid funding respectively, the process by which these rates are set should be integrated. This requires using consistent sources of base data and risk adjustment methodologies. DHS proposes referencing the CMS Medicaid rate setting checklist as a source of guidance on choosing appropriate base data and other methodological issues.[1]

Base Data

CMS and DHS should agree on and use the same source of base data to set rates for the demonstration program. Base data for rate setting should come from the population included in the program, or the most comparable population for which data can be obtained. Combined Medicaid and Medicare claims data for the specific population that would be eligible to enroll in the demonstration is the best available set of base data for rate setting.

DHS has Medicaid and Medicare claims data for dual eligible individuals for 2008-2010, and can identify within that data those individuals residing in a nursing home and meeting all other applicable criteria for enrollment in the Virtual PACE demonstration program. DHS also has Medicaid claims data for these individuals for 2011, and is attempting to obtain 2011 Medicare claims data as soon as it is available. DHS can share any or all of this data with CMS, including the Medicare data if CMS' own Medicare data is not accessible to the necessary individuals or in a format that allows the identification of this population, such as data not at a person level.

Risk Adjustment

CMS and DHS should also agree on the risk adjustment methodologies to be used in rate setting. A risk adjustment method developed for members residing in nursing homes or at a nursing home level of care will more accurately adjust payments for this population than any method developed from a larger population with overall less acute needs. Further, risk adjustment methodologies should be unified- not arbitrarily different for the Medicare funding vs. the Medicaid funding. The risk adjustment model may be different for acute & primary services vs. long term care services, if this adjusts payments more accurately as different factors better predict risk for different services, but the distinction should not be based on the funding source.

DHS proposes exploring the use of data specific to the population residing in nursing facilities to develop an appropriate risk adjustment model. Functional status data should be included in adjustment for long term care services, and diagnostic data for acute and primary services. The Minimum Data Set (MDS) provides a rich source of information

[1] This checklist can be found online at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1229570545276&ssbinary=true

on individuals residing in nursing facilities. In Wisconsin's existing long term care programs, data from the long term care functional screen (LTCFS) is used to develop a regression model predicting long term care costs. DHS could also explore the development of a similar regression model for the Virtual PACE population using MDS data. This might predict costs for long term care services, or, if the diagnostic information in the MDS data is sufficient to predict acute & primary costs, perhaps CMS and DHS could explore one model that predicts all costs. Alternatively, MDS data is already used in developing RUGS-based nursing home rates in both Medicare and Medicaid; another possibility is to use RUGS classifications in the development of rates for the long term care portions of the capitation rates, while considering other methods of risk adjustment for acute & primary services.

Savings Assumptions

Virtual PACE rates will include savings assumptions that yield up-front savings to each of CMS and DHS. Preliminary work at DHS and with DHS' contracted actuaries attempts to estimate the feasible savings, or range of savings, in each service area. Savings are expected primarily from reduced utilization due to improved care management and aligned financial incentives. DHS envisions that estimating savings assumptions to be applied to rates will also include estimates of any new care management and administrative costs, which will offset a portion of the savings from reduced service utilization. This series of estimates will result in a net savings estimate, a portion of which will be taken from the rate as up-front savings. It is vital that state input be incorporated into these savings estimates, and that all of the assumptions described above are clearly documented so that the process is transparent for all stakeholders.

Other Payment and Financial Issues

The above suggests key principles for a few major components of the rate setting methodology. Additional detail is needed on these, including considerations like adjustments to base year data for trend and other factors, establishment of specific rate cells, and any data smoothing techniques to be applied. Further, there are additional payment issues to consider, including but not limited to risk sharing agreements, stop-loss provisions, retroactive adjustments where acuity is different than assumed in prospective rate setting, incentives or withholds in years two and three of the demonstration, and any solvency requirements. DHS proposes that the Medicaid rate setting checklist referenced above be a source of guidance on each of these issues where applicable, and that this document informs an integrated process wherein CMS and DHS jointly make payment decisions for both components of the integrated rate.